Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MIDLAND MEMORIAL HOSPITAL
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name
ACE AMERICAN INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-11-4421-01

MFDR Date Received
July 21, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted several appeals to the carrier and per First Health they are reducing the claims prior to taking the PPO reductions which in this case there should be no reductions as per the contract which is included with this dispute claims are payable at 100% of the fee schedule allowable as of the 2007 contract."

Amount in Dispute: $2,365.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Reimbursement for the date of service in dispute was made pursuant to the fee schedule and Requestor's contract with Aetna and was paid accordingly."

Response Submitted by: Downs Stanford, PC, 115 Wild Basin Road, Suite 207, Austin, Texas 78746

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 26, 2010 to August 27, 2010	Outpatient Hospital Services	$2,365.58	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – Payment is included in the allowance for another service/procedure.
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 45 – Charges exceed your contracted/legislated fee arrangement.
   - 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
   - 59 – Processed based on multiple or concurrent procedure rules.
   - 96 – Non-covered charge(s).
   - P303 – This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business.
   - Z547 – This bill was reviewed in accordance with your Fee for Service contract with Coventry. For questions regarding this analysis, please call 1-800-937-6824.
   - Z652 – Recommendation of payment has been based on this procedure code,
     - 36415, which best describes services rendered.
     - 80048, which best describes services rendered.
     - 85025, which best describes services rendered.
     - 11012, which best describes services rendered.
     - 26746, which best describes services rendered.
     - 26862, which best describes services rendered.
     - 73140, which best describes services rendered.
     - 81003, which best describes services rendered.
     - 88304, which best describes services rendered.
     - A4565, which best describes services rendered.
     - J0690, which best describes services rendered.
     - J2250, which best describes services rendered.
   - Z710 – The charge for this procedure exceeds the fee schedule allowance.
   - XE27 – This is a packaged service based on Medicare guidelines as defined in the CMS-Publication 60A, which states: Packaged Revenue Codes The following revenue codes when billed under OPPS without HCPCS codes are packaged services for which no separate payment is made. However, the cost of these services is included in the transitional outpatient payment (TOP) and outlier calculations. The revenue codes for packaged services are: 0250, 0251, 0252, 0254, 0255, 0257, 0258, 0259, 0260, 0262, 0263, 0264, 0269, 0270, 0271, 0272, 0275, 0276, 0278, 0279, 0280, 0289, 0370, 0371, 0372, 0379, 0390, 0399, 0560, 0569, 0621, 0622, 0624, 0630, 0631, 0632, 0633, 0637, 0700, 0709, 0710, 0719, 0720, 0721, 0762, 0810, 0819 and 0942. Any other revenue codes that are billable on a hospital outpatient claim must contain a HCPCs code in order to assure payment under OPPS. Return to provider (RTP), claims which contain revenue codes that require a HCPCS code when no HCPCS code is shown on the line. No separate payment allowed.
   - ZOBC – The recommended allowance on this line is based on TX fee schedule reimbursement guidelines which allows greater than the providers billed charges.
   - U634 – Procedure code not separately payable under Medicare and or fee schedule guidelines.
   - 94 – Processed in Excess of charges.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason codes 45 – "Charges exceed your contracted/legislated fee arrangement;" P303 – This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business;" and Z547 – "This bill was reviewed in accordance with your Fee for Service contract with Coventry. For questions regarding this analysis, please call 1-800-937-6824." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on March 13, 2013, the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required that the insurance carrier, ACE American Insurance

Company, had been granted access to the provider's contractual fee arrangement. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code A4565 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75
   - Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $12.12. 125% of this amount is $15.15
   - Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.14. 125% of this amount is $13.93
   - Procedure code 81003 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.22. 125% of this amount is $4.03
   - Procedure code 88304 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0343, which, per OPPS Addendum A, has a payment rate of $35.73. This amount multiplied by 60% yields an unadjusted labor-related amount of $21.44. This amount multiplied by the annual wage index for this facility of 0.9347 yields an adjusted labor-related amount of $20.04. The non-labor related portion is 40% of the APC rate or $14.29. The sum of the labor and non-labor related amounts is $34.33. The cost of these services does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $34.33. This amount multiplied by 200% yields a MAR of $68.66.

- Procedure code 73140 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $44.90. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.94. This amount multiplied by the annual wage index for this facility of 0.9347 yields an adjusted labor-related amount of $25.18. The non-labor related portion is 40% of the APC rate or $17.96. The sum of the labor and non-labor related amounts is $43.14. The cost of these services does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $43.14. This amount multiplied by 200% yields a MAR of $86.28.
- Per Medicare policy, procedure code 26746 may not be reported with procedure code 26862 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code 11012 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0019, which, per OPPS Addendum A, has a payment rate of $294.06. This amount multiplied by 60% yields an unadjusted labor-related amount of $176.44. This amount multiplied by the annual wage index for this facility of 0.9347 yields an adjusted labor-related amount of $164.92. The non-labor related portion is 40% of the APC rate or $117.62. The sum of the labor and non-labor related amounts is $282.54. The cost of these services does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $282.54. This amount multiplied by 200% yields a MAR of $565.08.
- Per Medicare policy, procedure code 26862 may not be reported with procedure code 11012 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

4. The total allowable reimbursement for the services in dispute is $756.88. This amount less the amount previously paid by the insurance carrier of $3,019.22 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	May 10, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.